eBulletin

ARDSI CALCUTTA CHAPTER

Providing Dementia Care & Service since 1999

November, 2014

Two important documents were published by Alzheimer's Disease International this year which we take the opportunity to share with you all.

Dementia in the Asia Pacific Region
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Published by Alzheimer's Disease International, London, November 2014
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In 2006, the first report on Dementia in the Asia Pacific was published. Since then, there have been a number of developments in the region, including country-specific initiatives by governments and Alzheimer associations, as well as the availability of updated data. In addition, Alzheimer's Disease International (ADI) has increased its membership in the region from 15 to 18 members and, in 2013, established the Asia Pacific Regional Office (APRO) to intensify its efforts to support and strengthen member associations in the region. The APRO is based in Singapore.
In December 2013, the member associations at the Asia Pacific Regional Meeting in Hong Kong SAR agreed to commission an updated report for the following reasons:
1. To provide updates for governments/Health Ministries in the region.
2. To raise awareness through mainstream and social media to remove the stigma of dementia.
3. To increase the knowledge of strategies for dementia care and risk reduction for those interested in the cause.

This report :
- Describes dementia and the impact of the disease
- Provides updated prevalence and cost information for each country in the region.

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- Offers insights for each of the ADI member associations in the region and environment in which they operate.
- Suggests an integrated care pathway concept in relation to the journey of a person with dementia.
- Provides information on strategies for dementia care based on an updated framework of the ADI-Kyoto.

Declaration of 2004

- Provides evidence on risk reduction activities to help delay the onset of dementia.

This report also combines the ADI World Alzheimer's Month themes of the Journey of Caring (2013) and Risk Reduction (2014).

The facts

The 18 member associations of ADI in the Asia Pacific region are located in Australia, Bangladesh, China, Chinese Taipei, Hong Kong SAR, India, Indonesia, Japan, Macau SAR, Malaysia, Nepal, New Zealand, Pakistan, Philippines, Singapore, Republic of Korea, Sri Lanka and Thailand.

The population of the Asia Pacific region in 2015 is estimated at 4 billion based on ADI's categorisation of regions. Accordingly, estimates show that more than 11% of the population in the region is over 60 years of age1,2. It is expected that by 2050 a quarter of the total population in the Asia Pacific region will be aged 60 years or older.

Chapter 1 Executive summary

Alzheimer's Disease International 4 Report 2014 The increase in ageing also extends to the oldest-old or those aged 80 and over. The proportion of the oldest-old in the Asia Pacific region has increased dramatically; in 1990, the proportion of those aged 80 years and over was 0.8% which rose to 1.4% in 2012 with projections indicating this will increase to 4.4% by 2050.

Globally, the number of people with dementia in 2013 was estimated at 44 million people, rising to 76 million in 2030 and 135 million in 2050. In the Asia Pacific region, the number of people with dementia is estimated to increase from 23 million people in 2015 to 71 million people by the year 2050.

The worldwide costs associated with dementia are tremendous with estimates indicating that in 2010 US$604 billion was spent on the disease. These costs related to informal care (such as unpaid family carers), social care (community and residential care) and medical care (treatments in primary and secondary care). For the Asia Pacific region, costs associated with dementia have been estimated at US$185 billion.

The challenge

The Asia Pacific Region faces specific challenges relating to dementia including:

- Limited awareness of dementia and in many countries a cultural context that denies its existence or attaches stigma to dementia.
- An assumption that dementia is a natural part of ageing and not a result of a disease.
- Inadequate human and financial resources to meet the care needs of people with dementia and limited policy on dementia.
- Inadequate training for professional carers and lack of support for family carers

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Recommendations

The Asia Pacific countries already have around half of the world's population. The number of people living with dementia in the Asia Pacific region will triple between now and 2050. There is an urgent need for governments to put in place policies and plans to ensure that adequate care and services are provided to people living with dementia in the future.

The updated 2004 Kyoto Declaration provides a framework for action for governments, non-government organisations and other stakeholders in the Asia Pacific region. Here are the recommendations:

1. Provide education and awareness about Alzheimer's disease and other dementias, highlighting that dementia is not a normal part of ageing but a disease of the brain.
2. Improve the quality of life of people living with dementia by providing education to family members, paid carers and other health care professionals to ensure that the best quality of care is delivered to people living with dementia.
3. Promote the development of health and community care systems to deal with an increasing number of people with the disease. To the extent possible ensure that health and community care systems are adequately equipped to provide care and treatment, provide education or professional development to family, paid carers and health care workers, and adequately and continuously invest in health and community care systems.
4. Raise awareness of prevention and risk reduction strategies which may delay the onset of the disease for some individuals and reduce future numbers of people with dementia.
5. Countries to develop national dementia action plans detailing key areas for action including research, awareness and education, improving quality of care, prevention and risk reduction and assessment and diagnosis. The Kyoto Declaration provides a framework of possible strategies for countries to consider.
6. Promote and support further research into the health and care systems in lower and middle income countries in the development of health policy.

World Alzheimer Report 2014

The World Alzheimer Report 2014, Dementia and Risk Reduction: An analysis of protective and modifiable factors critically examines the evidence for the existence of modifiable risk factors for dementia.

It focuses on sets of potential modifiable risk factors in four key domains: developmental, psychological and psychosocial, lifestyle and cardiovascular conditions. The report makes recommendations to drive public health campaigns and disease prevention strategies.

Here is a summary of the report.

Background

This report examines critically the evidence for the existence of modifiable risk factors for dementia and focuses upon sets of potential modifiable risk factors in the following key domains: developmental, psychological and psychosocial, lifestyle and cardiovascular.

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Epidemiology is the discipline that studies the distribution, the causes and impact of health and ill health in populations. Epidemiology is mainly concerned with the estimation of the number of those affected by a certain health condition or trait in the population, and with the identification of risk factors for disease.

Prevalence is the proportion of those with the disease in a given population and is a broad measure, or a developing the disease. Prevalence and incidence are closely linked, prevalence being the product of incidence and duration of the disease episode. Because late-life dementia cannot be treated, duration essentially corresponds to survival. In other words, the number of those with dementia (i.e. dementia prevalence) depends on risk of developing the disease (i.e. incidence) and on the length of survival among those who are affected in the general population.

A large variety of potential risk and protective factors for dementia and cognitive impairment have been investigated in epidemiological studies and some of these have also been tested in experimental studies.

The current focus on modifiable risk factors is justified by their potential to be targeted for prevention at a population level. However, non-modifiable risk factors (eminently age, gender and genetic factors) are also very important. Although at present genetic factors cannot be modified they can be used to identify those at higher risk who may be targeted for subgroup prevention programs; and because complex gene-environment interactions likely exist the actual expression of these genes might be modified too.

Marked inter-individual differences in cognitive health in late-life are observed at a population-level. These differences may in part be a function of the level of exposure to a number of factors across the entire life course. In general, they are associated with an increased or reduced future likelihood of cognitive impairment and dementia in populations.

Because there are no established diagnostic biomarkers of dementia-related brain damage, and because the mechanisms that link this damage to the expression of dementia symptoms are not fully understood, prevention of dementia is commonly conceived as the delay of the clinical onset of the disease rather than a slowing or avoidance of the development of the underlying neuropathology. Similar to other chronic diseases primary prevention of dementia corresponds, ideally, to 'delay until death' of symptomatic onset, or, failing that a delaying or deferring of onset to older ages than that at which it would otherwise have occurred. Summary of risk factors.

The strongest evidence for possible causal associations with dementia are those of low education in early life, hypertension in midlife, and smoking and diabetes across the life course.

Improved detection and treatment of diabetes and hypertension, and smoking cessation, should be prioritised, including for older adults who are rarely specifically targeted in prevention programs. Increased physical activity and reduction in levels of obesity are also important.

There is considerable potential for reduction in dementia incidence associated with global improvements in access to secondary and tertiary education. There is also consistent evidence from several studies for an inverse association between cognitive activity in later-life and dementia incidence.

However, this association may not be causal, and the benefits of cognitively stimulating activities need to be tested in randomised controlled trials. While cardiovascular health is improving in many high income countries, it is deteriorating elsewhere. Many low and particularly middle income countries show a

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pattern of increasing cardiovascular conditions, hypertension and diabetes. The largest increase in dementia prevalence in the coming decades will be in the low and middle income countries, where the risk factors identified in this report present an increasing problem.

There is no evidence strong enough at this time to claim that lifestyle changes will prevent dementia on an individual basis. However, combining efforts to tackle the global burden and threat of NCDs is important.

Recommendations

There is persuasive evidence that the dementia risk for populations can be modified through reduction in tobacco use and better control and detection for hypertension and diabetes, as well as cardiovascular risk factors. A good mantra is "What is good for your heart is good for your brain".

Based on the evidence, brain health promotion messages should be integrated in public health promotion campaigns such as anti-tobacco or noncommunicable disease (NCD) awareness campaigns, with the message that it's never too late to make these changes.

This report strongly suggests that dementia needs to be included on World Health Organization (WHO) and national NCD planning. Research should test hypotheses on lifestyle and control of risk in randomised controlled trials when feasible, and explore other sources of evidence when it is not. The quality and relevance from observational studies should be enhanced (include any dementia as an outcome, harmonise exposure/outcomes, careful reviewing of systematic reviews and creation publicly accessible archives of data).

Conclusions

The future course of the global dementia epidemic is likely to depend crucially upon the success or otherwise of continuing efforts to improve global public health. Combining efforts to tackle the increasing global burden of NCDs will be strategically important, efficient and cost-effective. There may be potential to add to people's motivation to make and maintain changes in their physical activity, diet and smoking habit, to test for hypertension, cholesterol and diabetes, and adhere to prescribed treatments, if they understand that by doing so they may significantly reduce their risk of developing dementia in later life.

An important component of this message is that 'it is never too late'. The NCD prevention strategy focuses upon middle-aged persons, and the prevention of 'premature mortality'. However, evidence presented in our report suggests that control of diabetes, smoking cessation, and increases in physical and cognitive activity, have the potential to reduce the risk of dementia even in late-life.

Hence, while the message is becoming clear, the optimal prevention strategy, and the 'messaging' to achieve the desired objectives remain obscure. We are, in truth, at the foothills with a mountain to climb, in particular in comparison to the evidence base developed over the last 50 years to guide cardiovascular disease prevention and health promotion. Alzheimer's Disease International intends to follow-up this report with a selection of 'early adopter' case studies of brain health promotion and dementia prevention programmes, in an attempt to learn from these experiences, and understand which approaches are most likely to gain traction.

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If we can all enter old age with better developed, healthier brains we are likely to live longer, happier and more independent lives with a much reduced chance of developing dementia.

The World Alzheimer Report 2014 was independently researched and authored by Prof Martin & published by Alzheimer's Disease International (ADI). It is the international federation of Alzheimer associations throughout the world.

www.alz.co.uk

ARDSI Calcutta Activities

April – November, 2014

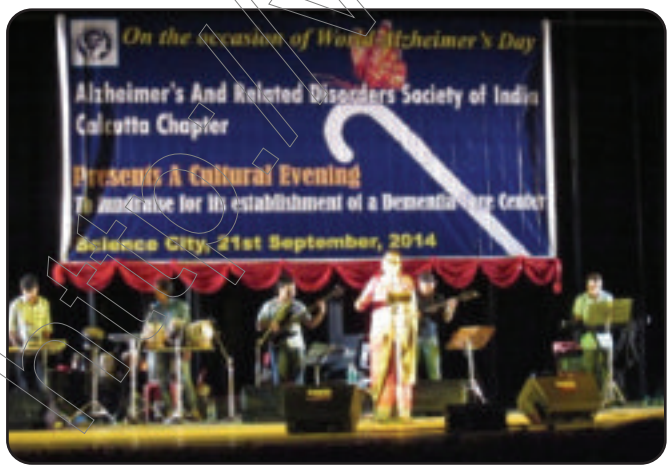
Accompanied with a vision to create widespread awareness and acceptance of Dementia throughout Eastern India via continued education and advocacy, **ARDSI Calcutta continued with its ongoing activities based on its value of:**

- Understanding the unique needs of people with dementia and their caregivers.
- Encouraging partnership & collaborative efforts.
- Accountability & Viability.
- Dignity & Respect.
- Innovation & Creativity.

The following months saw Awareness programs, Carer Meets, Training, Memory Screening camps, participation at Conferences and a month long World Alzheimer's program.

World Alzheimer's Month Program

Cycle Rally



Fundraiser

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Tram Tour

Street Play

Press Meet

Memory Screening Camp

Memory screening camp at "ELDER'S FAIR" CMDA Nagar Barrackpore, West Bengal; being organized by Geriatric Society Of India-West Bengal Branch, with co-organizers-Barrackpore Elderly Care Society (Member of Varistha Nagarik Manch of Help age India-klokata.), Titagarh Medical Association ofIMA, CMDA Nagar barrackpore cooperative housing society Ltd., Flat owners welfare association of CMDA BKP., & Puja committee of residents of CMDA.

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DayCare

Our daycare center is running well with 17 clients at present and booming with various meaningful activities.

Durga Festival Tour

Diwali Celebrations

Rakhi Celebrations

Cooking Sessions

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Awareness Programs

Awareness at Primary School

Awareness at Senior School

Awareness at a Housing complex

Awareness at AIWC branches

Awareness at AIWC branches

Opening of Dementia Clinic
at Chandernagore

Training Session with
Family & Professional Carers

Carer Meet

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Conferences:

Population aging is a global phenomenon. And the magnitude of dementia and its impact on the institutions of society is being recognised and realized. So, while it is important to develop policies and strategies for action, it is also important to join hands to improve understanding and share expertise and experience.

The 10th Annual National Conference of the Indian Association for Geriatric Mental Health (GERON-2014) was a step forward to the direction.

Brig. S P Bhattacharya, Executive Member of ARDSI Calcutta & Nilanjana Maulik, Secretary, ARDSI Calcutta presented at the GERON 2014 at Hyatt Regency Kolkata on 7th September, 2014.

Brig. S P Bhattacharya, Executive Member of ARDSI Calcutta & Nilanjana Maulik, Secretary, ARDSI Calcutta presented at the Asia Pacific Regional Conference, New Delhi, 7/8/9th of November, 2014. Nivedita Saha, Program Officer, ARDSI Calcutta also represented ARDSI Calcutta at the conference. This conference "Emerging challenges of dementia in the Asia Pacific Region" was being organised to bring together medical professionals, care providers, nursing and paramedical professionals; social and health organisations; and governmental agencies to deliberate on issues related to risk factors, preventive strategies, advocacy and policies for better facilities for diagnosis and care.

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Appeal

Our humble appeal for support continues. The limitations of finances remain perpetual and formidable obstacles for our society. We will appreciate if you could support the urgent cause of tackling dementia through our awareness, training, care-giving and research work.

Caring for this affected population is a joint effort of all those who can still reason and remember. We truly believe you share the same thought and will join us in our mission.

Please note that Cheque or draft should be in favour of "ARDSI Calcutta Chapter" for our awareness, training and care-giving programs and "ARDSI Calcutta Research Fund" for our research work.

For donations via bank transfer to ARDSI Calcutta Chapter within India
Send it to – Account Name: ARDSI CALCUTTA CHAPTER
A/C No. 10598348576 at SBI, Hazra Road Branch, Kolkata
IFS Code: SBIN0001649

For donations via bank transfer to the research fund
Send it to– Savings Account Name: ARDSI CALCUTTA RESEARCH FUND
A/c No. 32861811671 at SBI, Ballygunge Branch, Kolkata
IFS code is: SBIN0000018.

For donations via bank transfer from abroad to ARDSI Calcutta Chapter
Send it to– Savings Account Name: ARDSI CALCUTTA
A/c No. 11000018154 at SBI, Ballygunge Branch, Kolkata
Swift code is: SBININBB328.

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All donations to ARDSI Calcutta are eligible to Income Tax Relief under 80G applicable in India

ARDSI Calcutta is also registered under FCR ACT 2010 to receive donations from abroad

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